

**Rhode Island Executive Office of Health and Human Services  
 Early Intervention  
 SSIP Phase I  
 Baseline: 67.9  
 Targets:**

<b>FFY</b>	<b>2013</b>
<b>Data</b>	<b>67.9 %</b>

**FFY2013-FFY2018 Targets**

<b>FFY</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
	<b>67.9%</b>	<b>68.5%</b>	<b>69.7%</b>	<b>71.2%</b>	<b>72.9%</b>

Targets were developed by the SSIP Leadership Team with stakeholder input and are aligned with timelines of implementation of improvement strategies. The implementation plan for improvement strategies was presented to the Interagency Coordinating Council along with a timeline for expected rate of change for our SIMR. The ICC agreed with and approved the targets.

**Overview:**

**Rhode Island’s State Identified Measureable Results: Rhode Island has identified Indicator 3, Summary Statement A, Outcome 1 as the area of focus for the State Identified Measureable Results. Our SIMR will focus on a subpopulation of children whose families have participated in the Routines Based Interview (R. McWilliam) as a part of IFSP development. Children whose families have participated in the Routines Based Interview will substantially increase their rate of growth in development of positive social emotional skills by the time they exit the program.**

**The lead agency is the Rhode Island Executive Office of Health and Human Services (EOHHS). The Early Intervention program operates within the state Medicaid office. Rhode Island services approximately 4000 children yearly through a system of 11 local Early Intervention programs certified to provide Early Intervention.**

**The process included the development of an SSIP State Leadership Team (2/14/14) which included relevant stakeholders. Four members attended the NERRC SSIP Regional Meeting (3/19/14-3/20/14). This group has met at least monthly since that time. Members of the SSIP State Leadership Team completed individual assignments and brought them to the full group. Information from this Leadership Team was presented regularly to the Interagency Coordinating Council (ICC), and the RI Early Intervention Association (which includes state Part C staff, program directors, the RI Parent Information Network (RIPIN) Early Childhood Director, and our Comprehensive System of Personnel Development staff from the Paul V Sherlock Center on Disabilities at Rhode Island College).**

**The responsibilities of the ICC and the RI EI Association in the SSIP process included: reviewing, discussing and prompting questions to the reports provided by the Leadership Team; participation in reviewing APR data; reviewing other data; participation in a SWOT broad analysis of infrastructure and an in-depth infrastructure analysis; participation in target setting of the SIMR; providing input and feedback regarding improvement strategies and theory of action.**

**The SSIP Leadership Team included:**

**Brenda DuHamel, Part C Coordinator  
Donna Novak, Part C Quality Improvement and TA Specialist  
Christine Robin Payne, Part C Data Manager**

**Maureen Whelan, CSPD Coordinator, Paul V. Sherlock Center on Disabilities at Rhode Island College  
Leslie Bobrowski, CSPD Technical Assistance Specialist, Paul V. Sherlock Center on Disabilities at Rhode Island College**

**Paul V. Sherlock Center on Disabilities at Rhode Island College is a University Center for Excellence in Developmental Disabilities (UCEDD). UCEDDs are designed to increase the independence, productivity, and community integration and inclusion of individuals with developmental disabilities. In Rhode Island, the Sherlock Center partners with state and local government agencies, schools, institutions of higher education, and community providers. They offer training, technical assistance, service, research, and information sharing to promote the membership of individuals with disabilities in school, work and the community. The Sherlock Center on Disabilities provides the Comprehensive System of Professional Development for Early Intervention. This program includes two stakeholders: the CSPD Coordinator whose role was to provide input into the SSIP process from a statewide training and technical assistance perspective and a TA specialist whose role was to provide input into the SSIP process from the perspective of implementing improvement strategies. These two stakeholders are directly responsible for leading systems change.**

**Casey Ferrara, Meeting Street Early Intervention Director/ICC Member  
Meeting Street School is a non-profit center for educational and therapeutic services (Early Intervention, Early Head Start, an Early Learning Center which provides childcare for children 6weeks to 5 years and for young children with IEP's, K-5 Educational Program, Carter School-Middle and High School Special Needs Students and Healthy Families America, a national Maternal Health Home Visiting Program). Casey's role represents this agency as a stakeholder to provide input into the SSIP development process from the perspective of an Early Intervention provider. Meeting Street School operates the largest EI program in the state and Casey was identified as a critical participant on our Leadership Team because:  
a)the program is our largest and its data readily impacts state data; b) Casey**

demonstrates leadership in statewide EI activities; c) she is a member of the ICC and is a regular participant in the EI Association; and d) Meeting Street has an enthusiastic management team that recently increased APR compliance to 100% in all compliance indicators for SFY 12-13 and SFY13-14.

**Deborah Masland, ICC Chair, RI Parent Information Network, Early Childhood Director-**  
The Rhode Island Parent Information Network (RIPIN) is a statewide charitable, nonprofit association which provides direct linkages for parents and children with special health care needs in Rhode Island to obtain the critical services and supports needed in area of health care and education. This organization holds a contract with the Lead Agency to provide a parent support component for RI's EI system. RIPIN is responsible for recruitment, training, and support of parent consultants to work in targeted clinical settings that serve as referral sources for EI and others who work in each of the certified EI Programs. Parent consultants are family members of children with special needs who have themselves experienced EI and who provide parent to parent support. RIPIN is also responsible for the administration, collection, and reporting of Family Outcomes survey data and the development and provision of family workshops and trainings. The Director of Early Intervention and Early Childhood Programs is also chair of the Interagency Coordinating Council. This stakeholder's role was to ensure ICC involvement in the SSIP process from the onset and to provide perspective into the SSIP process from a parent advocacy perspective and as a parent of a child with disabilities.

**Karen McCurdy, University of RI, Chair of the Department of Human Development and Family Studies (HDF)**

**Alyssa Francis, URI HDF Graduate Assistant**

The Paul V. Sherlock Center on Disabilities has a sub-contract with University of Rhode Island to increase the number of qualified providers in the RI EI system and in careers involving children with special health care needs (CSHCN). Through this plan over 140 interns have been placed at various EI and CSHCN sites throughout Rhode Island (since 2006). Karen and Alyssa provided input into the SSIP process from a statistics and research perspective.

**SSIP Leadership Meetings occurred on: 4/17/14; 5/28/14; 6/11/14 (with SSIP TA call); 7/17/14; 8/14/14; 9/22/14; 10/16/14; 11/14/14; 12/10/14; 1/6/15; 1/13/15; 1/28/15; 2/24/15; 3/17/15**

**The responsibilities of the leadership team included:**

- leading the SSIP process;
- participating in a broad and in-depth data analysis and broad and in-depth infrastructure analysis;
- reviewing, soliciting feedback/questions and incorporating feedback from other stakeholder groups into the SSIP process;

- developing the potential SIMR for review and input by stakeholder groups; and
- the development of improvement strategies for review and input by stakeholder groups.

**The Rhode Island Interagency Coordinating Council was actively involved in the SSIP Process. The ICC includes representatives from:**

- Parents of children with developmental delays
- Early Intervention providers
- Rhode Island State Legislature
- CSPD staff
- Rhode Island Executive Office of Health and Human Resources (EOHHS, Lead agency for EI and state Medicaid agency)
- Rhode Island Department of Education (RIDE)
- Head Start
- Department of Children, Youth and Families (DCYF)
- Rhode Island Department of Health (HEALTH)
- Rhode Island Department of Business Regulation (DBR)/Office of Health Insurance Information (OHIC)
- Pediatrician
- Rhode Island Parent Information Network (RIPIN)
- RI Kids Count

a. Data Analysis: A description of how the State identified and analyzed key data, including data from SPP/APR indicators, to determine the areas for improvement. The description must include information about how the data were disaggregated in order to identify areas for improvement. In addition, the description must include any concerns about the quality of the data and how the State will address this, as well as methods and timelines to collect additional data that may be needed to inform areas for improvement. As part of its data analysis, the State should determine if there are any compliance issues that present barriers to achieving improved results for students with disabilities.

**The leadership team considered APR data and selected Indicator 3 (Child Outcomes) as the focus of our data analysis because our Family Outcomes targets were met in SFY 2012-13 and SFY 2013-2014 and these results were between 91.8%-94.4%. The team decided that Child Outcomes was an indicator where there was room for improvement in Summary Statement A (most recent results: 67.91%-76.69%), or Summary Statement B (52.08%-57.84%)**

**Quantitative data sources used included:**

- Child and family demographic data;
- APR data;
- state data related to child outcomes and family outcomes;
- national outcomes data;
- state eligibility data;
- provider self-assessment data;

- **focused monitoring data;**
- **IFSP Outcome review data (family owned, functional, measureable); and**
- **Services Rendered Form review data.**

**Qualitative methods included:**

- **review and discussion by the SSIP Leadership Team;**
- **review, discussion, and feedback by the ICC and the EI Association;**
- **surveys of directors and supervisors related to evaluation/assessment and professional development needs;**
- **themes identified over the course of the past year’s Early Intervention Supervisor Seminar; and**
- **a series of discussions with DCYF, EI providers, and community providers regarding the impact of trauma on health and development.**

**Process:**

**State child outcomes data is collected for all children enrolled in Early Intervention for 6 months or longer. This data is available on a pivot table in a spread sheet spanning multiple years updated quarterly and available to all EI Providers. Two members of the SSIP Leadership Team were responsible for organizing data for review by the SSIP team. Data was presented to the SSIP Leadership Team using the ECTA Broad Based Analysis Template as a guide.**

**The data reviewed by the team included: a review of state data for each outcome; trends over time; and a comparison of RI data to national data and a comparison across programs. The process generated questions and additional data for the team to review. An initial broad data report was presented to the ICC and the EI Association. Questions and hypotheses from those groups re: root causes of the lower Summary Statement A data in Outcome 1 were then reviewed and probed by the SSIP Leadership Team and included in the in-depth data analysis.**

**The in-depth analysis included intense disaggregation of the data. The ITCA category template (states with similar eligibility criteria) was used. In addition, our URI representatives conducted a statistical analysis of state outcomes data as part of the in-depth analysis. They provided the SSIP team information related to the statistical significance of data.**

**Other data considered were the IFSP Outcomes data generated from the provider self-assessment process and data generated by a review of a sample of Services Rendered Forms describing the content of EI visits. This data was discussed by the SSIP Leadership Team as it related to the root cause analysis. An in-depth data report was presented to the ICC and EI Association for review and feedback.**

Our broad based analysis showed that for Summary Statement A (increased rate of growth) children make the least amount of progress in Outcome 1 (positive social emotional skills) when compared to the other 2 outcomes. This trend has been consistent over time. Additionally, for the last three years RI results for Outcome 1 have remained the same whereas Outcomes 2 and 3 have increased over the last 3 years. It should be noted that RI is very close to national percentages overall. However, when we compared RI data to states with similar eligibility criteria, RI's data is lower for Outcome 1 but higher in outcomes 2 and 3.

In Summary Statement B (exiting with skills within age expectations), when we compared RI data to that of states with similar eligibility criteria, RI also had lower percentages lower in Outcome 1 but higher in Outcomes 2 and 3 .

- In 2012, 9/9 local providers show Outcome 1 as the lowest outcome in Summary Statement A (2 providers had N under 30 and were not included).
- In 2013, 7/10 local providers show Outcome 1 as their lowest outcome in Summary Statement A (1 provider had N under 30 and was not included).
- In 2014, 9/9 providers show Outcome 1 as their lowest outcome in Summary Statement A (2 providers has N under 30 and were not included).

This data pointed to a statewide issue. Because it is our lowest outcome we felt further analysis of this outcome was needed to determine whether the differences in the percentages between our outcomes was significant.

Qualitatively, EI directors and supervisors have expressed concerns about the press of time during the first 45 days to get a high quality assessment of a child and family's functioning. RI's eligibility criteria changed somewhat in 2013 when our system eliminated "multiple established conditions" as an eligibility condition and added "significant impact on child and family functioning" (without accompanying standardized scores below the mean). Understanding of these real life concerns (impact on functioning) occurs over time, but program managers felt that they were not getting enough functional information within the 45 day timeline. This was true especially in regards to social emotional development.

Rhode Island has the capacity to review our outcomes data in the following ways and these were reviewed as part of the analysis:

Provider	Gender	Discharge Status
Child	Language	(Completion of IFSP Prior to age 3; Part B eligible; Parent Withdrawal; Attempts to contact unsuccessful; etc.)
Outcomes 1, 2, 3	Insurance type	Referral Source
Entry Rating	(Private, Medicaid)	(Parent, Pediatrician, DCYF, First Connections, etc.)
Exit Rating	Length of Time in EI	Discharge Year
Score	Age at Referral	Missing Information
Summary Statement A ,B	Eligibility category	
Race		

**After disaggregating our data, the Leadership Team noted what the data did not show. It did not show a particular subgroup of children that make significantly less progress in Outcome 1 when compared to the other 2 outcomes. Initial hypotheses generated by stakeholders groups (such as an eligibility category of “single established condition” as a possible explanation) were not supported by the in-depth analysis. Our in-depth analysis examined change scores of each outcome (the percent of children who improved, who stayed the same, or got worse) and confirmed that the difference in change scores of Outcome 1 were statistically significant when compared to the other 2 outcomes. When looking at change scores by provider only 1 site has had consistently high scores across all three years in Outcome 1. By contrast 6 providers have consistently high change scores across all three years in Outcome 2 and 9 providers have consistently high change scores across 3 years in Outcome 3. The fact that most providers have low change scores in Outcome 1 pointed to a system wide issue.**

**The leadership team hypothesized that if providers were adequately assessing social emotional functioning, then if we examined entry scores of a sub-set of DCYF referrals (children removed from their homes older than 12 months of age) we would expect that circumstances would have impacted their social emotional functioning and be reflected in their entry ratings. We would expect that these children would not be rated a 6 or 7 (age expected skills).**

**Our disaggregated data of CAPTA referrals who were between 12 and 24 months at referral showed 43% rated a 6 or 7 at entry in Outcome 1; by contrast only 20% were rated a 6 or 7 in Outcome 2 and 10% were rated a 6 or 7 in outcome 3. Although this N is small (N=30) our conclusion is that providers do not identify social emotional needs as well as they identify physical, cognitive or language delays/needs in the other 2 Outcomes. The identification of social emotional needs may occur after the entry ratings are developed and after the working partnership with families has developed. This would explain the high % who stay the same or get worse in Outcome 1.**

**Our in-depth analysis showed age at referral as a statistically significant factor. The younger the child referred the less progress in Outcome 1. This corresponds to qualitative data from EI directors and supervisors who have indicated that evaluation/assessment of social emotional development of younger infants is challenging. We concluded that professional development in this area was needed.**

**Other highlights of disaggregated data include:**

**Gender: When gender was compared to see if changes by outcome area was significantly different, females showed significantly ( $P < .05$ ) more improvement in outcome 3 compared to males. Females also rated higher in outcome 2 compared to males. There was no significant difference in ratings by gender in social emotional skills**

**Insurance:** There was no significant difference by insurance (Medicaid, Private). RI does not collect data related to family income however insurance funded by Medicaid would indicate socioeconomic status

**Age:** When analyzing paired samples related to change scores there was a significant relationship between age at referral and changes in social emotional scores and Taking Appropriate Action to Meet Needs scores. Particularly, the older the child was when referred the greater the change in Outcome 1. The younger the child was when referred the greater the change in Outcome 3.

**Race:** There were no significant differences by race.

### **Data Quality**

One of RI's strength's is the quality of our data. Data quality was reviewed using the RI Quality Data Report prepared by ECTA which shows RI consistently higher than the national average over time in the completeness of its data and in collecting enough data. RI patterns and ranges for the progress categories reviewed by ECTA are well below the maximum percentages for expected patterns. RI data trends over time do not show large shifts or changes which would indicate questionable data. We regularly monitor missing data and there are provider tools to proactively find missing data. We have the ability to disaggregate the data and provide technical assistance around data which looks to have quality issues. As part of our disaggregation of the data by discharge category we identified children eligible for Part B yet rated age appropriate. The ID's of those children were given to providers for a quality review. The overwhelming majority upon further investigation reported these children were eligible for Part B due to articulation issues and were eligible for walk-in speech services only, and the ratings were in fact appropriate.

RI data is of good quality however we have recently changed our Child Outcomes Summary Form (COSF) to organize the summaries of functioning into 3 categories: age expected, immediate foundational, and foundational skills. This will not only organize the observations/knowledge of providers but will improve programs' ability to monitor the ratings for reliability and validity. We have included our process/requirements for measuring child and family outcomes in state policy and have required quality assurance protocols regarding child outcomes data. We require that all staff be trained in the child outcomes process prior to using it. We will continue to monitor data to identify data quality issues

### **Compliance Data**

A review of APR indicators shows RI compliance data has improved significantly since our base line data was established. Technical Assistance related to compliance has evolved to isolated issues in specific programs. For the most part, most providers have developed programmatic systems to manage compliance and therefore compliance is less of a statewide issue. The majority of providers have incorporated compliance into their

**scheduling, quality assurance procedures, and supervision. This leaves room to devote energy to further program improvement in order to improve outcomes for children and families.**

**A provider who encounters capacity issues will be impacted in their ability meet compliance indicators and staff will be needed to address compliance. This may impact the ability to participate in professional development and TA activities related to our SIMR. Programs with compliance issues will have the opportunity to correct non-compliance and delay participation in SIMR related professional development activities until they are compliant.**

b. Infrastructure to Support Improvement and Build Capacity: A description of how the State analyzed the capacity of its current system to support improvement and build capacity in EIS programs and providers to implement, scale up, and sustain evidence-based practices to improve results for infants and toddlers with disabilities and their families, and the results of this analysis. State system components include: governance, fiscal, quality standards, professional development, data, technical assistance, and accountability. The description must include the strengths of the system, how components of the system are coordinated, and areas for improvement within and across components of the system. The description must also include an analysis of initiatives in the State, including early childhood initiatives within the State's lead agency for Part C and other early childhood initiatives, which can have an impact on infants and toddlers and their families with disabilities. The State must include in the description how decisions are made within the State system and the representatives (e.g., agencies, positions, individuals) that must be involved in planning for systematic improvements in the State system.

**A broad infrastructure analysis was done using a SWOT analysis by the ICC and the RI EI Association. The SSIP Infrastructure Analysis Guide was completed and reviewed and by 3 members of the leadership team. That group presented an adaptation of the guide to conduct an in depth infrastructure analysis by our SSIP Leadership Team. That analysis was shared with the EI Association who contributed additional input into to the document. A new document which included both the State Leadership Team and EI Association's analysis was presented to the ICC for further feedback and input.**

## **Infrastructure Analysis**

### **Governance/Lead Agency**

**The lead agency is the Executive Office of Health and Human Services-this office is also the lead agency for the state Medicaid program.**

**Part C leadership consists of: the Part C Coordinator; Part C Data Manager; Quality Assurance Project Specialist; the CSPD Coordinator and CSPD Technical Assistance Specialist. The team meets weekly to inform each other and administer the EI system. The leadership team is small and accessible which allows for simplified and inclusive decision making.**

**RI is a small state and early on in our SSIP process our leadership infrastructure was identified as strength by our stakeholders and something that contributed to the benefits experienced by eligible children and families. Our EI structure is aligned to support our SIMR in many ways.**

**Our Early Intervention system is supported by a committed network of 11 EI programs whose directors meet face to face each month as the EI Association. The Part C Coordinator, Quality Assurance Specialist, CSPD Coordinator, CSPD TA Specialist, and the RIPIN Early Childhood Director also are members of this group. The CSPD Coordinator and CSPD TA specialist meet monthly with EI supervisors as part of a Supervisors Seminar focusing on reflective supervision. This seminar is also used as a vehicle for sharing statewide information and resources, soliciting feedback, and to support leadership in the RI EI service delivery model.**

**These components of our system allow for effective, real time communication, opportunities to collect and use feedback, and relationship building. Whenever a new initiative or system change is considered, our structure allows for a process which ensures representation by EI providers in the development phase of any change. Those managers review the anticipated change with their staff and to elicit feedback from the field. This information is brought back to the larger group for further consideration. These stages ensure that all programs are aware of the proposed changes, the reasons for them, and optimize efforts for an effective roll out. This way of “doing business” develops leadership skills of program staff. For each initiative a core group of providers is “deputized” to help implement the change.**

**Systems change in RI includes the support, commitment and resources of the Lead Agency, is led by our CSPD component, and utilizes a leadership group within our EI system to help implement the change.**

**Understanding the EI service delivery model by the larger community, and even referral sources, has been identified as a barrier to families’ understanding of the EI service delivery model (i.e., service based on real life functioning rather than just developmental skills performance). Our SIMR is based on evidence based practices aligned with the RI service delivery model. We need to develop a plan for better understanding by external stakeholders such as pediatricians, and improve our written materials for parents. We will need to develop materials for staff and parents which will explain the evidence based practices we will be incorporating into our work for our SIMR.**

**Fiscal:**

**RI State law requires public and private insurance to cover EI services. Because the lead agency operates within the state Medicaid office the lead agency is responsible to establish statewide EI reimbursement policies and rates for private and public insurers. This is strength because the RI EI Medicaid Reimbursement Guidebook is aligned with billing practices associated with our SIMR.**

**Part C funds are utilized to support professional development. Part C has received additional funding for professional development activities through Race to the Top which will be leveraged to fund professional development activities related to our SIMR until 2015-16. An area to address is a plan to develop funding professional development**

activities related to the SIMR when Race to the Top funds will no longer be available. Providers have indicated the loss of income when allowing staff to participate in professional development activities is a financial burden. We have addressed this barrier with Race to the Top funds through 2016 but will need to develop a budget within our CSPD contract after that. Providers have also indicated that some activities related to early intervention are not reimbursable (e.g. cancellations and no shows). Our SIMR may actually help with this issue but we will need a data collection plan that demonstrates how.

## **Quality Standards**

RI has developed Certification Standards which all Early Intervention providers must adhere. We have standards related to qualified personnel and we have developed detailed competencies for Early Intervention staff. As part of RI Certification Standards we have included Principles and Practices which are based on nationally recognized evidence based practices (Key Principles and Practices). The Rhode Island Medical Assistance Claim Reimbursement Guidebook for EI Services is aligned with these practices. Our RI Child Outcomes Developmental Guidance document has been cross walked with the RI Early Learning Development Standards. Having our COSF age anchored guidance tool aligned with RI Early Learning Standards supports our SIMR. The Rhode Island Medical Assistance Claim Reimbursement Guidebook for EI Services is aligned with RI Principles and Practices. This makes for good alignment between the Quality Standards component with Fiscal and Professional Development components.

## **Professional Development**

Rhode Island's Part C's Comprehensive System of Personnel Development (CSPD) is embedded in all components of RI's Early Intervention (EI) system. Through a contract with the Paul V. Sherlock Center on Disabilities, the lead agency for EI, the Executive Office of Health and Human Services (EOHHS), fulfills its responsibility to maintain such a system.

Important functions of our CSPD include:

- Recruitment and retention of qualified staff
- Increased workforce capacity
- Professional development and technical assistance for the current workforce
- Leadership development across the system

In addition the CSPD focuses on supporting the lead agency to meet all the requirements of a Part C system as well as promoting a high quality, evidence-based service delivery model. In this capacity, Sherlock Center staff work on policy development as well as operationalizing policy in practice. Capacity building and system improvement are critical tasks for the technical assistance that Sherlock Center staff provides to EOHHS and the Part C Coordinator. Incorporating our SIMR as a focus for our CSPD and TA components will fit naturally as part of our CSPD, TA system. Our SIMR can be incorporated into our Introduction to Early Intervention course which is required for all new staff. SIMR professional development activities will be carried out by this component.

**The Coordinator and TA Specialist are part of the state leadership team making this component directly aligned with Governance, RI Quality Standards, Technical Assistance, Data and Fiscal components. Our CSPD was identified as a strength by our stakeholders.**

## **Data**

**The state utilizes a robust web based data system. The system is used by programs for care coordination. Data is used by the state to monitor compliance, performance, and the costs of EI. The data component informs the state's fiscal, accountability and CSPD components. Professional Development and TA is informed by the data component in developing needed activities and priorities. The data manager is a member of the state's decision making team aligning Data and Governance components. An identified area of improvement of our system is to provide better tools for providers to capture cancellations which was an identified weakness.**

## **Technical Assistance**

**There are two full time state-level technical assistance providers and the contract's budget allows for the utilization of expertise from other in-state clinicians as well as supporting professional development and consultation from outside entities. TA to individual programs occurs regularly. Sometimes this occurs on an 'as needed' basis and other times it is more formalized and planned (e.g., in the development and implementation of Corrective Action Plans).**

**Through the use of consultants with expertise in early childhood, quality assurance, or infant mental health, additional resources and expertise are contributed to the Part C system. This practice has also assured leadership development within this system.**

## **Accountability and Monitoring**

**The state uses a self-assessment process along with on-site focused monitoring to all providers annually. Compliance with self-assessment is verified by sample record review by state staff. The CSPD Coordinator participates in all focused monitoring site visits. Corrective Action Plans (CAPs) for noncompliance are required for federal compliance indicators and Provider Improvement Plans (PIPs) are required for quality indicators. TA is provided in the development of Corrective Action Plans and Program Improvement Plans. The Accountability and Monitoring component directly informs the CSPD and TA components. Our SIMR is in alignment with our yearly self-assessment and site visits. Currently we review IFSP outcomes as a state priority area in yearly record reviews. We expect improvement in the writing of family owned functional outcomes because of our SIMR and we will be able to measure that as part of focused monitoring.**

## **Analysis of Initiatives**

**Part C is a leader in the new RI Early Childhood Comprehensive Assessment System initiative (through Race to the Top). This project will use national experts and current research to review state-level evaluation/assessment policies for Part C and for Part B (Section 619). Funds from Race to the Top will be leveraged to develop and provide professional development based on these policies and are closely related to our SIMR.**

**The ICC Work Group on CAPTA referrals is an initiative that is developing an updated interagency agreement between the DCYF and the lead agency. The impact of trauma is directly related to social emotional development which is the focus area of our SIMR**

**RI's CSPD has supported the training of 4 EI staff in RBI. 3 of them are now certified as trainers. RBI will be a major focus of our SIMR and this initiative will provide the foundation. In January 2015 a pilot project was initiated to train 7 staff from 2 EI programs in RBI. The pilot will assist our CSPD in developing effective ways to change our system and to identify and remove barriers and implement our SIMR.**

**Two members of our CSPD staff and 6 EI supervisors have participated in professional development on coaching provided by Dathan Rush (2013) . Coaching will be a component of professional development/technical assistance improvement activities to support our SIMR.**

**Reflective Supervision is a required, reimbursable component of our EI system. Reflective practice is included in state policies. It has been included in RI Principles and Practices. The EI Supervisor Seminar is a part of our CSPD structure and meets monthly to: 1) support skill development in reflective supervision; 2) provide leadership development for the supervisors re: our service delivery model, and 3) to provide meaningful networking and sharing of information across programs and between programs and the lead agency. The impact of trauma on children and families has been the focus of the EI Supervisor Seminar (2014-2015). Presentations were provided by Child Witness to Violence staff (Boston) and a clinician from the Center for Early Relationships at the Jewish Families and Children Service (Waltham/Boston). Ongoing case consultation from this clinician was provided to the supervisors through the year. In 2015 the ARC treatment model (for Attachment, Regulation, and Competency by Margaret Blaustein and Kristine Kinniburgh) will be the focus of this seminar. Our SIMR is aligned with this work. The EI Supervisors group will be key in providing guidance for staff related to our SIMR. The SIMR is aligned with their on-going staff supervision.**

**Infant Mental Health Competencies- RI Association for Infant Mental Health, Bradley Hospital, and Department of Children Youth and Families have purchased the Michigan Early Childhood Mental Health Competency Guidelines to address professional development gaps in the larger system. This initiative has potential to support our SIMR. We have strong collaborative ties to all 3 of these entities.**

**RI CSPD has (2014) presented professional development on: 1) “ Child Development: How to use for insight and for partnering with families”, and 2) “Child Assessment: increase your skills and impact your practice”**

**Current CSPD plans for 2015 include professional development on: 1) evaluation/assessment of infants (a repeat from 2012), and 2) evaluation/assessment of social emotional skills: what makes a high quality process. Annual CSPD needs assessment survey is still being completed. Our SIMR is aligned with these staff development opportunities.**

**State review of IFSP Outcomes has been part of focused monitoring for SFY 2013 and SFY2014. Outcomes were reviewed and rated by EI providers in the self-assessment process and verified by focused monitoring. PIPs were required in 2013 and TA was provided to individual sites as part of PIPs. Programs submitted samples of IFSP outcomes to the CSPD Coordinator and direct TA was provided regarding outcomes. Providers who have not made improvement will receive individual TA in 2015. The development of outcomes that are family owned, functional and measureable is directly related to our SIMR. This initiative is aligned and will continue to support our SIMR.**

**Our CSPD has drafted guidance regarding how to decide on IFSP services. This initiative will support our SIMR.**

**RIDE Part B has recently developed a “Tip Sheet” to all districts re: ensuring that social emotional development is included in evaluation for eligibility. Our SIMR is aligned this Part B initiative.**

**RI EOHHS Patient Centered Medical Home (“PCMH Kids.”) – This grant initiative operating out of the EOHHS Medicaid office focuses on providing better care coordination for children with high needs, including medical, behavioral health and/or social needs. We will leverage this pilot as a way to inform pediatricians about our service delivery model. This initiative will be leveraged to assist with an identified SIMR barrier regarding pediatricians’ knowledge about the EI service delivery model and how they describe it to families they are referring.**

**A Part B/619 and Part C collaborative initiative successfully developed new state competencies for early childhood special educators that include EI. These include competencies related to engagement with and coaching of families, and home-based service delivery. Students graduating in the field will have competencies aligned with EI.**

c. State-identified Measurable Result(s) for Infants and Toddlers with Disabilities and their Families: A statement of the result(s) the State intends to achieve through the implementation of the SSIP. The State-identified Measurable Result(s) for Infants and Toddlers with Disabilities and their Families must be aligned to an SPP/APR indicator or a component of an SPP/APR indicator. The State-identified Measurable Result(s) for Infants and Toddlers with Disabilities and their Families must be clearly based on the Data and State Infrastructure Analyses and must be a child- or family-level outcome in contrast to a process outcome. The State may select a single result (e.g., increase the rate of growth in infants and toddlers demonstrating positive social-emotional skills) or a cluster of related results (e.g., increase the percentage reported under child outcome B under Indicator 3 of the SPP/APR (knowledge and skills) and

increase the percentage trend reported for families under Indicator 4 (helping their child develop and learn)).

***SIMR: Rhode Island will increase the percentage of children showing greater than expected growth in positive social emotional skills (Summary Statement A for Outcome #1). Our SIMR focuses on a subpopulation of children whose families have participated in a family directed assessment utilizing the Routines-Based Interview (Robin McWilliam)***

**Process used for selection of the SIMR: Our SSIP Leadership Team provided results of our initial data analysis to the RI EI Association and to the ICC. Questions and probes from these two groups shaped our next level of analysis. We reviewed the percent of children's progress for this outcome disaggregated in many ways, including:**

- **program,**
- **referral source,**
- **ethnicity,**
- **insurance,**
- **age at time of referral,**
- **length of time in EI**
- **discharge status**

**The data did not indicate that progress results for a sub-population of children or a sub-set of providers were driving our state data. Reviewing the meaning of this new data, we saw that our Outcome 1 (rate of growth) results were significantly lower than the other 2 outcomes across the entire system. The Leadership Team reviewed Child Find data and confirmed that our Child Find efforts are excellent (2.94% for birth to 1, and 6.42% for birth to 3/ Indicators 5 and 6) indicating children are found eligible (in spite of struggles with the evaluation/assessment of social emotional skills).**

**The quality of our child outcomes data (Quality Data Report prepared by ECTA) and its consistency indicated to the Leadership Team that providers understood the COSF process and its rating system. That developed into our hypothesis that low results in Outcome 1 came from a "blind spot" in the area of evaluation/assessment of social emotional skills. Additionally, a review of IFSP outcomes and Services Rendered Forms (as part of a separate quality review) showed that few IFSP outcomes focused on social emotional skills (e.g., relationships, understanding of child/adult behavior, responsive parenting, regulation, etc.) and few were tied closely to the regular routines and activities that made up families' lives.**

**After reviewing all potential options, the Leadership Team with input from stakeholders determined that our SIMR should focus on ensuring a more comprehensive, functional assessment for a sub-set of our providers. The team identified the RBI (Robin McWilliam) as an assessment practice which, when implemented statewide with fidelity, would improve RI's percentage of children with substantially increased rate growth in social emotional development.**

**The RBI was selected because:**

- it is evidenced based;
- it utilizes an interactive process that quickly establishes a relationship between the interviewer and the caregiver;
- it helps the parent identify concerns related to their child’s engagement, independence and social relationships in everyday routines (all elements of positive social emotional development);
- and it leads directly to the development of relevant IFSP outcomes.

**Our 3 certified RBI trainers made presentations to our SSIP Leadership Group, the EI Association, and the EI Supervisor Seminar. All 3 groups were impressed by the potential for increasing the specificity and functionality of our IFSPs. These trainers stressed how this process would improve our ability to address social emotional/relationship-based issues that were not otherwise being adequately addressed.**

**RI intends to implement the RBI statewide. Although we anticipated providing training in its use we had not envisioned statewide implementation. The SSIP process provided us with a structured way to refine our intentions and redefine what possible re was: expanding RBI implementation. Implementing this practice effectively will require long-term planning and a committed team of leaders. Scaling up the use of the RBI will take time and resources and is an excellent choice for our SIMR. As a result of scaling up RBI implementation (and other related professional development initiatives) we expect that the percentage of children with significantly improved social emotional functioning will be greater for those whose families have participated in the RBI process.**

**We will begin with a pilot cohort of 2 EI programs. Cohorts will be added throughout the course of the SSIP. Factors considered in selecting programs for each cohort include program size, child outcomes data, compliance data, and program willingness to participate.**

Cohort	FY14-15	FY15-16	FY16-17	FY17-18	FY18-19
Cohort 1	Program A				
	Program B				
Cohort 2		Program C			
		Program D			
Cohort 3			Program E		
			Program F		
Cohort 4				Program G	
				Program H	
				Program I	
Cohort 5					Program J
					Program K

**As RBI practice becomes statewide, the overall numbers of children whose families have participated in the RBI will increase and as those children exit the program we expect that the overall percentage of children who demonstrate increased rates of growth of positive**

social emotional skills will grow. Several factors need to be taken into consideration in determining when we will see the impact RBI has had.

Our data analysis shows that approximately 40% of children are enrolled in EI for 6-12 months; 45% are enrolled between 13-24 months and 14% are enrolled for 25 months or longer. We expect that once a program begins to implement the RBI the impact will be small since not all staff will be trained at the same time. In addition most children will not exit until 1-2 years have passed.

We expect gains to show in the second and third years of a programs implementation. Our expectation is that by the end of the SSIP the 6 programs in Cohorts 1, 2, and 3 will have completely implemented the RBI and enough time will have passed so that the families of all children enrolled will have had an RBI. We expect that the percentage of children who demonstrate increased rates of growth in social emotional skills in these programs will increase by 6.5 percentage points. The 5 programs in Cohorts 4-5 will have begun implementation later and therefore we expect a smaller impact by FY18. The overall SIMR will increase by at least 5% by FY18.

Our SIMR was selected because:

- our data analysis indicates that RI's percentage of children with substantially increased progress in social emotional development is lower than the other two outcomes;
- analysis of the data confirmed that the percentage difference between Outcome 1 results and the other 2 outcomes was significant;
- infrastructure analysis also demonstrated a system wide need for professional development in high quality evaluation/assessment procedures
- data also suggested that the child outcomes ratings process was not the issue but rather the lack of identification of social emotional concerns of infants and toddlers and their families;
- it is highly aligned with Part C and state early childhood initiatives, especially RI CSPD initiatives and RI Early Childhood Comprehensive Evaluation/Assessment System (Race to the Top initiative);
- it is based on our infrastructure analysis and is aligned with our system's strengths (our leadership and policy structure), our CSPD and other related TA components; and
- positive social emotional development is critically important in the development of every child

Our SIMR was presented to stakeholders in the EI Association and ICC by the Leadership Team. A presentation regarding the RBI was also presented by 3 certified trainers regarding the process. Feedback regarding the SIMR was solicited, and possible barriers regarding implementation were identified. The SIMR was approved and targets were approved by the ICC.

d. Identification of the Focus for Improvement: A description of improvement strategies on which the State will focus that will lead to a measurable child-based result. The State must include in the

description how the data analysis led to the identification of the area on which the State will focus. The State must demonstrate how addressing this area of focus for improvement will build the capacity of EIS programs and providers and supports to improve the identified result for infants and toddlers and their families with disabilities. (For example, the State might be working to improve the validity and representativeness of their data on early childhood outcomes and family involvement.)

**Improvement strategies were based on the results of the data and infrastructure analysis. The State Leadership Team used an adaptation of the SSIP Infrastructure Analysis Guide which contained input from the State Leadership Team, EI Association and ICC stakeholder groups. Improvement strategies were developed by a sub-set of the Leadership Team and brought to the full team for review, feedback, and editing. Improvement strategies were presented to the EI Association and ICC for review and feedback.**

**RI's SSIP improvement strategies were selected to specifically target needed provider skills and infrastructure support to do a better assessment of family life and concerns and better address those concerns. Our strategies are largely the responsibility of our CSPD component, which was identified as one of our system's strengths. These strategies utilize other strengths of infrastructure:**

- **our consistent use of ad hoc leadership teams to develop and promote new initiatives,**
- **our system for collecting and using provider feedback, and**
- **our ability to regularly provide on-site technical assistance and support.**

### **Primary Improvement Strategies**

**RI has identified 4 primary improvement strategies to improve child outcomes related to social emotional development.**

- 1. We will provide professional development focused on high quality evaluation procedures for social emotional development. This need had already been identified for our EI system. The structure of the SSIP will provide the needed framework for planning sustainable professional development and implementation.**

**We will use funding through the RI Early Childhood Comprehensive Assessment System project (through Race to the Top) to provide professional development and guidance documents focusing on high quality evaluation procedures (especially social emotional development). This is to ensure that we are correctly identifying eligible children when there is a concern in this area of development. We will also develop a sustainable training module on the components of high quality evaluation/assessment of social emotional development.**

- 2. We will provide professional development and site-based coaching and technical assistance on Routines Based Interviews. Funds leveraged through Race to the Top will be used for initial professional development activities and to fund a pilot initiative starting in January 2015 of 2 EI programs. RI expects to replicate the pilot in additional cohorts over the course of the SSIP.**

**The pilot cohort will enable RI to build program-level leadership teams to demonstrate and champion the RBI statewide. Initially, staff involved in the pilot were selected based on: their foundational knowledge/experience with RI's EI service delivery model, their readiness to take on new learning, and their identity as leaders among their peers. These staff, their supervisors, and other EI managers (not part of the pilot but who wanted to learn more about RBI) participated in a full day training on the RBI. The content and learning activities were developed and presented by the three certified RBI trainers in our system.**

**Each team will receive site-based technical assistance and coaching to support competency and fidelity. Observation, use of a fidelity checklist, video submission/review, and coaching feedback will be provided by the trainers. Additional groups of staff (5-6 in each group) from these two programs will participate in the RBI training until all relevant staff (those who do intakes and/or evaluations) are trained. Further training and site-based TA will be provided to the other members of these teams so that they understand RBI and the impact on outcomes and services.**

**The pilot will provide valuable information related to training, and identification of issues and barriers to resolve before each new cohort begins. Each program's designated RBI leadership team will coach staff within their own programs. Coaching and TA will also be provided by CSPD staff. The pilot will be repeated over the course of the SSIP in 5 cohorts.**

**A state wide "Kick Off" with Robin Mc William is planned and will occur in August 2015. All EI programs will select an RBI leadership team to participate in this 2 day conference.**

**During the pilot, data will be collected to monitor the impact of RBI (e.g., IFSP outcomes of pilot participants; cancellation rates; SRF Reviews). Data collected will include:**

**Impact on EI providers**

- **Review of written evaluation summaries re: social emotional skills (compared to baseline)**
- **Use of RBI fidelity checklist in the field**
- **Review of IFSP outcomes for those targeting child engagement, independence, and social relationships.**
- **Services Rendered Forms (SRFs) documenting services to support families' ability to improve children's social emotional functioning.**

**Impact on families**

- **Use of a self-assessment rating scale on how well did their IFSP accurately reflect their needs (compared to a [non-pilot] control group).**
- **Self-rating on how actively they were involved in the development of their IFSPs (also with a comparison group).**

- Self-rating on how successful they were in using IFSP strategies during their daily activities with their children (control group).

**Impact on children**

- Review of Child Outcomes entry ratings (compared to control group).
- Mid-point Child Outcomes rating on children whose families have had an RBI.
- Exit ratings of children whose families have had an RBI (as this group grows over time) and % of significant progress.

3. We will provide enhanced site-based technical assistance and review of IFSP outcomes. RI recognizes that professional development focusing only on the RBI will not ensure its effective use in the IFSP process. Technical assistance will be provided to each program in the cohort re: linking results of the RBI (family priorities) to the development of relevant IFSP outcomes. Enhanced technical assistance will also focus secondarily on the education of collateral team members (who will not be implementing RBIs with families) re: the impact of RBI on service delivery.

In addition, RI has a process already in place for the ongoing provision of technical assistance related to developing/reviewing IFSP outcomes. We will add a new review component to ensure effective RBI documentation and clear links to IFSP outcomes as part of our monitoring system. This will occur during our annual site-based record review visits as well as when needed/requested by individual programs. Programs whose records demonstrate a lack of alignment with the RBI and IFSP outcomes will be required to complete a Program Improvement Plan for RBI use and effective outcomes development.

4. We will expand professional development re: evidence-based practices for promoting social emotional functioning and positive relationships. We will provide professional development related to evidence based practices for when there are social emotional/relationship concerns. We currently have program staff who have completed training in Circle of Security-Parenting (COS-P). Our CSPD provided financial support for their participation in training and facilitates regular sessions of these staff to network, to support peer efforts to use this practice, and to brainstorm ways to increase the use of COS-P in our state. The RI EI Supervisor Seminar is engaged in a year-long process of self-study of the ARC Treatment Model for children and families impacted by trauma.

We have found that communities of practice established after a relevant training has increased the use of these practices. We will expand these groups.

In addition to these primary improvement strategies, the following activities have also been identified as part of our initial work plan. These activities form a “to do” list related to supporting our primary strategies.

- **Revise the RI Medical Assistance Claim Reimbursement Guidebook to include reimbursement for the RBI**
- **Develop a budget for anticipated PD and TA needs and review Sherlock Center contract/work plan.**
- **Modify the data system to identify families who have participated in the RBI process**
- **Explore data system documentation of cancellations (as a way to look at family engagement)**
- **Draft new public awareness materials that better explain/promote the use of RBI and the development of functional/relationship-based outcomes rather than narrowly developmental skills.**
- **Develop RBI guidance documents.**
- **Develop site-specific procedures for RBI and IFSP development**
- **Complete scaling up/PD to all programs**
- **Develop plan to revise current RBI module within Introduction to EI, a required 4 day course for all new providers**
- **Modify annual program self-assessment/monitoring tool to include review of RBI documentation and links to IFSP outcomes.**

e. Theory of Action: Based on the data analysis and infrastructure analysis, the State must describe the general improvement strategies that will need to be carried out and the outcomes that will need to be met to achieve the State-identified, measurable improvement in results for infants and toddlers and their families with disabilities. The State must include in the description the changes in the State system, and EIS program and provider practices, that must occur to achieve the State-identified, measurable improvement in results for infants and toddlers with disabilities and their families. States should consider developing a logic model that shows the relationship between the activities and the outcomes that the State expects to achieve over a multi-year period

**Based on our data analysis and infrastructure analysis RI has identified 4 major improvement strategies which will be led our CSPD component. The graphic on the following page illustrates how each strategy will impact provider practices related to IFSP development with the family which in turn will impact the competence and confidence of the family and ultimately result in improved social emotional outcomes. Versions of our theory of action were developed by individuals and small group members of the Leadership Team. The final version was presented to and approved by the ICC.**

## Rhode Island Early Intervention Theory of Action

***SIMR: Rhode Island will increase the percentage of children showing greater than expected growth in positive social emotional skills (Summary Statement A for Outcome #1). Our SIMR focuses on a subpopulation of children whose families have participated in a family directed assessment utilizing the Routines-Based Interview (Robin McWilliam)***

